MENTALLY DISORDERED OFFENDERS IN PRISON: A TALE OF NEGLECT?

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Abstract

The Prison Service's increased emphasis on security and control has generated many obstacles for the effective delivery of psychiatric care to mentally disordered prisoners. Such prisoners do not have the necessary mental strength or coping mechanisms to deal with the 'prison culture' and this is particularly so for women, young people and ethnic minorities. Conflicting ideologies between the prison regime and the NHS mean that the mental health services available to prisoners are limited. Therapeutic communities offer a potential solution to the dire situation the Prison Service finds itself in.

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Introduction

Prisons have long been associated with punishment, deprivation and poor conditions, but it is only recently that prisons have been linked to the treatment and human rights violations of mentally disordered prisoners. The early 20th century represented a reformist change in what had been an overwhelmingly punitive ideology within prisons. In respect of mentally disordered offenders, this reformist perspective acted upon some of the experimental methods of treatment being developed in the fields of psychology, psychiatry and psychotherapy (Harding et al, 1985). Such treatment, especially in terms of psychiatry, became an integral part of medical provision for the mentally disordered in the wider society and this was finally recognised by the courts with the introduction of the Mental Deficiency Act 1913. This diverted mental 'defectives' from the penal system to more appropriate institutions where specialist treatment was available. This type of legislation was developed further through the Mental Health Act 1959, article 65 of which dealt with dangerous mental offenders by enabling courts to couple a hospital order with a restriction order, making release from hospital dependent on the Home Office's consent (Harding et al, 1985). Both Acts aimed at removing the mentally ill from the prison system altogether, essentially making their criminal status secondary to their primary need for hospital treatment. However, many mentally disordered offenders were not classified under the 1959 Act and therefore remained in the prison system. Diversion, while imperfect, did attempt to provide medical treatment rather than imprisonment. Yet even this limited attempt to provide humane care and control for mentally disordered offenders was soon to fall victim to other social events. The steady rise in the overall prison population, the widespread decarceration of patients held in long-stay mental hospitals in the 1960s and 1970s, and the problems surrounding the system of community care to provide effective treatment for serious cases of mental illness have all contributed to a significant increase in the number of people held in prison who are suffering from mental health problems (Davies 2002).

The Prison Service has a duty of care to all of its inmates, but mentally disordered offenders are frequently denied such care. Sim (1990) has argued that psychiatric intervention in prison, while being put forward as a method of care and treatment, was actually deployed as a means of control. Moreover, the Mountbatten Report in 1966, following a series of escapes from high security prisons, led to greater emphasis on security and control. Such an emphasis caused many problems for the effective delivery of psychiatric care (Fitzgerald and Sim 1982). Unnecessarily restrictive conditions led to the inhibition of work, education and health needs, and 'activities of special units like Grendon Underwood psychiatric prison are curtailed in the name of security' (Smith 1984, p.14). Such disregard for the needs of mentally disordered offenders raises human rights issues, and argues for a better treatment approach within prisons (Starmer et al 2001; Bean 1986; Gostin 1977).

Prison as a Counter-Therapeutic Regime

Prison 'culture' is based on the principles of punishment, security and control, which conflicts with a health service emphasis on welfare and care. The prison regime was developed to provide a punishment that removes offenders from society, exercises maximum control over their daily lives and attempts to rehabilitate and deter them from offending again on release. Such a closed and punitive environment often has damaging effects on prisoners' psychological wellbeing, even though the majority develop coping mechanisms to overcome these effects (Gunn et al, 1978). However, do those prisoners already suffering from mental illness have the necessary mental strength to develop such coping mechanisms? This depends on several factors, such as individual character, the particular illness, the length of sentence and the medical resources within the prison. Her Majesty's Chief Inspector of Prisons (HMCIP) reported in 2002 that 41% of inmates in dispersal prisons should ideally be placed in secure hospitals or psychiatric wards due to the extent of their mental illness (HMCIP 2002, p.57). Even in 1996 the Inspectorate recognised serious problems regarding the treatment of mental illness.

> We are concerned in particular about the number of prisoners with mental problems, whose condition in prison is more likely to worsen than improve…prison can exacerbate mental health problems, which has a long term impact on the individual concerned and the community into which they are released (HMCIP 1996, pp.22-23).

In response, the government and the Prison Service attempted to find solutions which allow for the high numbers of mentally disordered offenders to stay in prisons, rather than removing them entirely to resolve the problems that have arisen. These solutions include 'in-reach' mental health teams and the extension of psychiatric wards within prisons. However, such improvements have had little effect on the actual experience of mentally disordered prisoners and on the factors detrimental to their wellbeing. The core argument relating to mentally disordered offenders is the dichotomy between the Prison Service ideology of security and control, and the health service ideology of welfare and care. Prisoners keep their human rights and therefore are entitled to the same health care as citizens in the wider society. The introduction of NHS 'in-reach teams' has exacerbated this culture clash between control and care (Stephens and Becker 1994). Research by The Sainsbury Centre for Mental Health (SCMH) reported difficulties in the relationship between the NHS and the Prison Service, describing it as an 'arranged marriage of two very different ideologies' (SCMH 2006, p.12). Most in-reach staff found it difficult working in an environment where security was prioritised over health and felt that the potential successes of some treatments were inhibited accordingly (SCMH 2006). 'Lockdowns' in prison are the epitome of security and control and overrule other activities taking place at that time, which is counter-therapeutic for mentally disordered prisoners because it is detrimental to the provision of the already minimal health service they receive. Research has shown that there is a 30–35% non-attendance rate at in-reach appointments and that security measures and the prison routine itself have a significant role to play in this (SCMH 2006, p.12). The goal of in-reach teams is to provide a mental health service equivalent to that offered in the community. It could be argued that because the prison regime values security measures over health matters, it denies mentally ill prisoners the health services they require and in turn disregards their basic human rights.

The regime experienced by mentally disordered *remand* prisoners is, if anything, worse. Cavadino's evaluation of three prisons in England concluded that 'all were totally unsuitable places in terms of regime and physical conditions in which to house mentally ill people' (Cavadino 1999, p.58). He argued that holding such people on remand was not done because of the seriousness of their offences but their apparent need for help; 'the courts were using remand prisons as social and psychiatric assessment and referral centres' (Cavadino 1999, p.58). This criminalisation of the mentally ill is in breach of their civil liberties and their due process rights that protect against such abuses of the legal system. Juliet Lyon, director of the Prison Reform Trust, states that 'the use of prison to warehouse people for their mental illness is a criminal use of our justice system, it makes ill people worse and disrupts the rehabilitative work of prisons' (Lyon 2005, p.1). The large scale closure of long-stay asylums since the 1970s has led to a seven-fold increase in the number of mentally ill men and women in the prison system (Davies 2002, p.2). The inability of care in the community to cater effectively for the needs of many of such people has resulted in the courts increasingly using prisons as a 'dumping ground' for this marginalised sector of society.
Another issue to be considered here is how the prison regime allows punishment to be extended in the form of unjust, biased or exploitative treatment by both the prison officers and the prison inmates. In the past, there has been considerable evidence to suggest misconduct by prison staff.

> The idea that prison doctors drug prisoners, close their eyes to brutality, identify with prison governors rather than prisoners, and think of prisoners as prisoners first and patients second is deeply rooted – among both the public and the doctors (Smith 1984, p.7).

Such actions and the often inappropriate practice of placing seriously mentally ill prisoners in special cells or segregation units, coupled with excessive use of control and constraint measures by officers (HMCIP 2001a, p.38) may be said to contravene Article 2 of the European Convention on Human Rights in terms of the protection from inhumane and/or degrading punishment or treatment (Starmer et al 2001, p.19).

The occurrence of abuse, exploitation and violence within the prison regime does not only apply to prison staff. Such behaviour is common among inmates who inhabit a 'prison culture' in part made up of illegal drug use and sale, exploitation for money, sexual abuse and the formation of groups who inflict abuse on others. This creates an environment of fear, resentment and depression. Little surprise, therefore, when the Health Minister stated that 'it is generally accepted that mental health will deteriorate in prison' (Ladyman 2004, p.2). Furthermore, a parliamentary mental health group 'has taken evidence on the victimisation of mentally ill prisoners who reported being robbed, bullied and indecently assaulted' (Davies 2002, p.2). The Prison Service is not upholding mentally ill prisoners' human rights to security and protection. In fact, it has been put forward that prison governors 'underestimate the isolation and bullying of the mentally ill in prison and the stigma of mental illness in such a situation' (The Mental Health Commission 2004, p.2). As Ruck (1951, p.8) stated 'prisoners are sent to prison *as* punishment not *for* punishment'. This issue directly relates to Article 14 of the European Convention on Human Rights, which prohibits discrimination on any grounds (Starmer et al 2001, p.2). To suffer degrading and abusive treatment is counter-therapeutic for mentally ill prisoners. These breaches of human rights signify

the unsuitability of the regime for such offenders. The question ‘prisoner or patient?’ is crucial since the concepts of punishment and care cannot easily co-exist, especially when prisons house both those suffering from mental illness, and those who are not, and attempt to treat them all under the same regime.

Mental Health Services in Prisons

In the 1990s the Prison Service came under increasing strain to meet the needs of mentally disordered offenders, and also saw some significant developments designed to improve the Service's duty of care to such inmates. The National Service Framework (NSF) in September 1999 began the modernisation of mental health services in prisons. This partnership between the NHS and the Prison Service was intended to improve the quality of mental health care so that, in theory, it would be equal to that obtained in the community (Towl et al 2002, p.161). The framework contained seven standards outlining ways in which prison health care could be improved; including, for example, the idea that integration between the NHS and prison health care staff was of great importance in order to aid the transfer of skills and the exchange of information. It also suggested that prisoners with mental health problems should be diverted from prison health care centres to day care and wing-based treatments, in an attempt to mirror the service provided in the community and with a view to creating a normal environment with a purposeful regime of activities for such patients. This report led to the development of a new strategy for the improvement of mental health care, jointly produced by the Department of Health and the Prison Service. 'Changing the Outlook' clearly stated that:

> Prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS (DH & HMPS 2001, p.5).

This report was influential in promoting the principle of equivalence of care and it recommended the introduction of specialist mental health teams to work alongside prison health staff. In concordance with these ideas, the government introduced mental health 'in-reach teams' to support prisoners with the most serious mental health problems and to provide an equivalent function to community mental health teams (DH & HMPS 2001). They also aimed to provide a multidisciplinary service, including nursing, psychology, psychiatry, social work and occupational therapy. On paper this appeared to be an effective step towards improving the situation of mental health care provision in prisons. However, in practice, it has become apparent that the weaknesses of the in-reach teams often outweigh their positive impact. The Sainsbury Centre for Mental Health researched eight London prisons and highlighted many of the limitations placed on the in-reach teams.

> Unlike the new teams in the community, such as crisis resolution and early intervention in psychoses, there has been no implementation guidance or any evidence to guide the teams and those commissioning them (SCMH 2006, p.6).

All in-reach teams intended to focus their attention upon prisoners suffering from severe and enduring mental illnesses. However, many of the prison health care staff disagreed with such exclusivity, based on their knowledge that prisoners with moderate mental illnesses often have complex needs and require further, specialist, help (SCMH 2006). Had 'evidence' been sought to provide guidance, then perhaps areas such as co-morbidity of moderate mental illness, which often requires advanced skills and multifaceted treatment, would have been included in the in-reach teams' work. A second criticism of the exclusive treatment offered by in-reach teams is simply that the term 'severe and enduring mental illness' is too vague and allows for

conflict in opinion between staff, especially in terms of substance misuse which would come under 'enduring' in most cases. These conflicting ideas created a rift between the prison and NHS staff, which in turn led to a failure to follow the NSF framework - encouraging the integration and exchange of skills between all staff. Further difficulties associated with the Framework can be seen in the quality of care experienced by more vulnerable groups of prisoners, such as young people, ethnic minorities and women.

There is a high prevalence of poor mental health among young people in prison; 95% suffer at least one mental health problem and 80% suffer two or more (Lader et al. 2000, p.4). On first view it can be seen that young people dominate the health care provided in prisons and therefore one could easily assume this to be a positive step towards managing this epidemic. The Chief Inspector of Prisons stated that some health care units were 'in effect an acute forensic adolescent psychiatric unit' (HMCIP 2005, p.14). Due to the limited number of beds available, this suggests that patients outside this group have restricted access to care. The second point to be made about this statement is that the majority of the 95% of young people suffering are actually not included in the group that dominate the health care units. The epidemic of mental health problems is due to the mild and moderate illnesses that require primary care. It appears that the government's plan for the in-reach teams was based on the idea that they would reduce the pressure placed on health care units by administering treatment and care in wing-based and day care units. However, the fact that they only focus on the severely ill means that there is still little or no primary care for mild mental problems even though there is a dire need of such care for young people who are 18 times more likely to commit suicide in prison than in the community (Prison Reform Trust 2005). It must also be taken into account that approximately 53% of suicides are committed by prisoners with no mental ill health on their records (Leibling & Krarup 1993, p.83), so it can be seen that young people suffering mild illnesses that go unnoticed are vulnerable to a decline in their mental state, which can have severe consequences.

Research into mental health among ethnic minorities in prison has shown that there is less mental ill health among African-Caribbean prisoners than among white prisoners (Coid et al. 2002, pp.473-80). However, these findings may be due to a lack of recognition by staff and a reluctance to seek help among this group of prisoners (Rickford & Edgar 2005). This suggests that the onus is on the Prison Service and NHS staff to be more effective, especially when examining ethnic minority prisoners for mental health problems. Research has also shown that screening procedures in prisons are often ineffective and prisoners with mental health disorders are frequently placed in ordinary locations (Parsons et al. 2001, pp.194-202) and once placed there problems are unlikely to be recognised during the sentence (Birmingham et al. 1998, pp.202-13). In relation to this, Haycock (1989) suggests that predominantly white prison officers selectively attend to intentional self injury (ISI) and that significantly lower rates of ISI among black prisoners is not actually because they rarely self injure, but in fact due to officers ignoring it. Such treatment of ethnic minority prisoners is a breach of their human right to protection from discrimination.

Women are twice as likely as men to report having received help for mental or emotional problems in the year before going to prison (Singleton et al. 1998), placing a great strain on mental health care provision upon arrival in jail. Rickford (2003)

found that two thirds of women in prison showed symptoms of at least one neurotic disorder such as depression, anxiety and phobias. Even more alarming, however, was Rickford's finding that 14% of women in prison suffered from a severe mental disorder such as schizophrenia or delusional disorders, which compares with less than 1% of the general population (Wilson 2005, p.56). Such a volume of mental ill health is difficult to cater for. However, it seems at least that the Prison Service is providing adequate medication; Rickford's (2003) research found that half of the women in prison receive prescribed medication and that one sixth are treated with hypnotic or anxiolytic medication. He also found that only 17% of women in prison had been taking medication for depression or anxiety before their prison sentence began, so therefore over half were prescribed medication whilst in prison. This research is supported by the Revolving Doors Agency (2004, p.1) which surveyed 1,400 women in HMP Holloway and found that 33% were taking medication for mental health problems on entering prison (the higher figure is due to the fact that Rickford's research only covered depression and anxiety rather than 'mental health problems' as a whole). A follow-up inspection by HM Inspectorate of Prisons found that 90-95% of prisoners in HMP Holloway were on psychotropic medication, primarily using benzodiazepines (HMCIP 2001, p.4). This is a substantial rise in figures and could suggest that prison triggers the onset of mental health disorders. However Rickford offers an opposing view;

> This increase in medication is not a result of careful exploration of the mental health needs of women in prison, but rather a response by under-trained staff who resort to medication to contain a problem (Rickford 2003, p.23).

This suggests that medication is being over-prescribed in order to help staff manage their patients more easily, a view supported by the Sainsbury Centre for Mental Health whose research discovered a similar attitude towards medication prescription in one London prison (SCMH 2006, p.14): 'Medical staff were quick to prescribe sleeping pills and antidepressants and lacked skills to help individuals who were self harming.'

If this is the case then it poses a human rights issue and is in breach of security and welfare rights. It is morally wrong that patients should be 'drugged up' because the Prison Service does not have the resources to handle and care for them. However, if the reason for this rise in medication is genuinely due to an increase in mental ill health, then the detrimental effects of imprisonment on mental states needs to be researched further, and a plan for the future needs to be sought. It is unacceptable to have up to 95% of women in prison on medication in order to get them through their sentences.

There is also some evidence that the lack of relevant staff training contributes to the difficulties of providing good quality mental health care. Pearce (2004, pp.47-8) found that 58% of prison doctors working with patients suffering mental health disorders have not received any psychiatric training. This research is supported by Read and Lyne (2000, pp.1420-4) who discovered that in the 13 prisons they inspected, only 24% of the nurses had mental health training and that none of the doctors attending to inpatients had received any specialist psychiatric training at all. So how can it be said that the Prison Service is providing mental health provision of

equal standard and quality to that found in the community, when those administering the treatment are not properly trained? It is clear that the needs of mentally ill offenders in prison are extensive, the range of illnesses and needs are wide, and it is a very complex job for staff to cater for such diversity. However this *is* their job and it is disappointing to see that not all the difficulties faced by mental health services stem from their actual structure and delivery systems. Research by the Howard League has shown that prison staff attitudes, particularly towards women, with mental health issues were 'negative and uncaring' and 'the majority viewed women displaying symptoms as manipulative and attention seeking' (HLPR 2001, p.58). Considering the government's 'equivalence of care' principle this type of scepticism and stereotyping of female prisoners is unacceptable, and such attitudes are not mirrored in the community mental health teams. This could also be considered discriminatory and therefore in breach of prisoners' human rights.

Conclusion - New Developments or the same Failures?

There is one potential solution to many of the problems set out above, but one which currently exists largely in isolation from the rest of the prison regime – the therapeutic community at Grendon Underwood prison. A therapeutic community such as Grendon, or in a few other small units within prisons, typically employs a range of multidisciplinary staff including nurses, psychiatrists, doctors, psychologists, psychotherapists, social workers and probation officers. The community values concepts such as collective responsibility, citizenship and empowerment and they are deliberately structured in a way that encourages personal responsibility (Campling 2001, p.365). The idea behind such regimes is the assumption that a community of care and respect is formed through the relationships between staff and prisoners in an environment where inmates are not punished for their abnormal behaviour, but openly discuss it in order to help them develop their personal functioning and control (Newell 1996). This involves the introduction of social, ethical and moral values and staff attempt to teach inmates how to understand the dangers that arise when these are corrupted (Roberts 1997). These aims take on the battle of modifying their future behaviours and therefore address the grating issue of recidivism, which is a very positive aspect of the therapeutic regime in terms of the wider society. It is important to recognise that therapeutic communities were developed to house prisoners suffering personality and mental disorders who are often extremely vulnerable to harm from others and themselves. Such prisoners, however, can also be threatening, violent and dangerous towards others, especially in an environment such as prison whereby agitation and anger are commonplace emotions. Therefore their removal to therapeutic communities is advantageous to the rest of the prison system considering that such offenders can cause significant disruption.

Although therapeutic communities continued to exist, their work has been over-shadowed by the introduction of 'in-reach' teams and the research and analysis involved with it. Cullen (1997) provides a second reason for the lack of support for the therapeutic regime; the emergence of individualism which has strengthened the drive for individual freedom of expression and independence. This idea insinuates that individualism has had a detrimental effect on society's duty of care for its citizens, including those caught up in the prison system. It is in the public interest for the 'social framework' to include prisoners because the vast majority of them will be released into society once more, with the potential to re-offend. Cullen (1997) suggests that this change in attitude towards individualism undermines and devalues the support that can be provided in a community environment, which is evident in the wider society, but especially so in prison. This is an important issue in terms of the development of therapeutic communities because it affects the government and the general public opinion on what constitutes 'just' punishment and 'just' treatment. Another key issue which has potentially reduced the research interest into prison therapeutic communities is the dispute between the medical tradition of treating patients and the primary purpose of imprisonment; to contain and control criminals in secure conditions (Kennard and Roberts 1983). It is within this context that the therapeutic community has been both commended and criticised.

Meta-analysis of the literature surrounding therapeutic communities shows how effective it is in the treatment for personality disorder (Dolan 1997) and for psychopathic offenders (Jones 1997). Genders and Player (1995) confirmed the findings of several earlier studies that the work of therapeutic regimes produced

significant improvements in the relevant personality characteristics; reduced levels of introversion, neuroticism, depression, anxiety and hostility. Newton and Thornton (1997) found that therapeutic community treatment resulted in lower levels of psychoticism, reduced levels of hostility and an increased belief in self control. Earlier work by Newton (1994) found that inmates released from Grendon were significantly less likely to be reconvicted within two years than those from mainstream prisons. The therapeutic community is the only regime that provides hope for offenders suffering from psychopathy; in-reach teams do not provide mental healthcare for such individuals because they are considered 'untreatable'. Psychopaths almost inevitably cause disruption in prison; 'they disregard social control and convention, in particular, they reject authority and discipline and their behaviour does not alter in response to punishment' (Cooke 1997, p.105). Their unsuitability to the prison regime appears obvious, if more so for the staff and other inmates if not for the individuals themselves.

> The justification of a therapeutic community approach…comes not only from the relief of intrapsychic distress caused by the disorder itself, but also by a concomitant reduction in the risk posed to others by the acting out of those patients/prisoners in impulsive or premeditated destructive acts of violence, abuse or self-injury (Cullen 1997, p.88).

Moreover, a Prison's Inspectorate report on Grendon in 2004 stated that it was an 'exceptionally safe prison [where] self harm was minimal and systems to prevent it were first rate' (HMCIP 2004, p.4). The Prison Service has a duty to protect all its prisoners from potential harm, and considering the evidence it would seem clear that those suffering psychopathy should not be placed in mainstream prison settings.

The core criticism regarding the use of therapeutic communities within a prison setting is based on the principle that treatment and punishment cannot effectively occur within one institution. 'The evidence over the last four decades of therapy in the total institution approach practised at Grendon, is that, on balance, it has been possible to sustain a therapeutic ethos within a security-conscious institution' (Cullen 1997, p.97). It appears that this is, in fact, possible and with very significant and positive results. The progression in the treatment of mental health problems has been extremely successful and this has resulted in a great reduction in violent, deviant or self-harming behaviour. 'The prison service may have much to learn from the therapeutic model in this context' (HMCIP 2004, p.4). Security and control of the offenders within a therapeutic community becomes the work not only of the staff, but also the inmates and this is one aspect of the regime which is exceptional. This therefore provides the observation, security and therapy needed for vulnerable and suicidal prisoners in a caring rather than controlling manner.

Despite the achievements of therapeutic communities they receive criticism for their rejection of the prison ideology of authoritative control and the manner in which they devolve decision-making to inmates. It has been argued that they do not constitute punishment and therefore offenders are not fulfilling their sentences. These differing perspectives come from the continuous struggle as to whether mentally disordered offenders should be considered 'prisoners or patients' It has become apparent that secure therapeutic communities allow them to be both; prisoners in terms of their

removal from society and loss of liberty, and patients in terms of the therapy they receive and the supportive community to which they belong.

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